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Testimony on:

HealthWave Program Structure and Overview

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HealthWave Program Structure and Overview

Good morning Madame Chair. I am Marci Nielsen, Executive Director of the Kansas Health Policy Authority (KHPA). I want to thank you for today's opportunity to provide information on the Medicaid and the SCHIP programs, together known as the Kansas HealthWave program. This morning you will also hear from several of our contracting vendors who provide critical services to our beneficiaries.

One of the KHPA's important responsibilities is to provide access to quality health care to low income Kansans. We take seriously the agency's statutory mission to ensure access to health care services for our beneficiaries and to be responsible stewards for the resources entrusted to us by the citizens and State of Kansas. As Executive Director, I want to share with you an overview of the Kansas HealthWave Program including information on managed care organizations, our eligibility clearinghouse, modifications in our dental program, our behavioral health contractor for Title XXI, and some of the future directions for our program.

Background

This committee requires a yearly update on the State Children's Health Insurance Program (SCHIP), otherwise known as HealthWave Title XXI. As you are aware, the S-CHIP program is a federal and state partnership created to expand health insurance coverage to children whose families are not income eligible for Title XIX Medicaid. Federal regulations refer, specifically, to targeted low income children who reside in families with incomes below 200.0 percent of the Federal Poverty Level (FPL) or incomes 50.0 percent higher than a state's Title XIX Medicaid eligibility requirement. In Kansas, SCHIP is available statewide to children who are Kansas residents from birth to age 19 and who live in families with incomes up to 200.0 percent of FPL, which is an income of $33,000 for a family of three.

The SCHIP program was implemented in Kansas in January of 1999. It was integrated with the state's Medicaid capitated managed care program in State FY 2002 in order to provide a seamless combined program known as HealthWave. Blending the two programs and providing coverage in a capitated format, as directed by the State SCHIP statutes, allows the State to provide children and eligible families with uniform and seamless health care coverage, regardless of which program (i.e., Title XIX or Title XXI) funds the coverage. The current income thresholds are shown in Attachment 1, which indicates the stairstep of eligibility between Title XIX Medicaid and Title XXI SCHIP. The Title XIX Medicaid income threshold for infants (age 0-5) is higher, 150.0% of FPL, compared to 100.0% of FPL for children over the age of 6. SCHIP funding is used to provide health coverage for children in these age groups above the Medicaid eligibility levels up to 200.0% of FPL. As of June 2006, 37,631 Kansas children were enrolled in HealthWave Title XXI. Total service expenditures in FY 06 for these children totalled $62.4 million.

As of June 2006, 37,631 children were enrolled in HealthWave XXI. Total service expenditures in state FY 06 for these children were $62.4 million. As of the same date, 64,468 children were enrolled in HealthWave XIX, along with 13,402 adults. Total expenditures in state FY 06 for HealthWave XIX beneficiaries, including those services paid outside of the capitated contract, were $198.4 million. In total, the HealthWave program provided services to 174,066 unduplicated beneficiaries over the fiscal year for $260.7 million, of which $81.9 million was from state funds. The number of unduplicated beneficiaries is greater than the totals for June, because beneficiaries enter and leave the program throughout the year.

Children are ineligible for SCHIP if they are currently covered by other health insurance or are eligible for Title XIX Medicaid coverage. Families with incomes over 150% of the poverty level who are interested in SCHIP coverage must pay a monthly premium (see appendix). Eligibility is determined annually and twelve months of continuous eligibility is applicable to SCHIP enrollees, even if family income increases above the income threshold during that time period.

The federal funding for HealthWave Title XXI is based on a capped annual grant. The federal law authorizing SCHIP expires in September of 2007, and KHPA has received no information concerning continued funding for SCHIP after Federal FY 2007. Kansas has spent its total allotted federal grant dollars since 2000 and has subsequently received some funds reallocated from other states. It is unclear whether Kansas will receive any reallocated funds this year. Federal funding should be fully expended by May 2007, including carryover and redistributions from other states. However, the Deficit Reduction Act contains provisions that ensure funds thru federal fiscal year 2007 for states that spend all of their funds.

Service Provision and Managed Care Organizations

The State currently contracts with a managed care organization (MCO), Centene/FirstGuard Health Plan of Kansas, Inc., to provide a full array of physical health care services. This contract will end December 31, 2006, and beneficiaries will be transitioned to two new MCOs. Through a contractual arrangement, Centene/Cenpatico Behavioral Health provides mental health and substance abuse treatment services for HealthWave Title XXI members. Healthwave Title XXI members receive dental services outside of managed care in a fee for service model. Title XIX beneficiaries receive mental health, substance abuse and dental services outside of managed care in a fee for service model as well.

As you may be aware, at the end of August KHPA announced two new managed care providers for beneficiaries in the HealthWave Program. KHPA awarded a statewide contract to UniCare Health Plan of Kansas, Inc. and a contract for Northeastern (Region I) and Southeastern (Region II) Kansas to Children's Mercy Family Health Partners; these contracts will begin on January 1, 2007. By choosing these two vendors, it is anticipated that the state will save between $10 and $15 million annually.

KHPA was required by state procurement laws and federal law to conduct a competitive Request For Proposal (RFP) process in contracting for these new services. The RFP process was aimed at providing choices to our beneficiaries through competition that could provide quality health services cost-effectively. KHPA cited both affordability and technical proposals in its decision to award the new MCO contracts. The RFP process began in February of this year when the Request for Proposal was issued by the then Division of Health Policy and Finance, and concluded in August. The timeframe for the transition was also set during the RFP process. Our legal obligation to engage in a competitive process and our commitment to provide the enhanced services possible through managed health plans brings us into this period of transition.

In the time period shortly following the announcement of the contract awards, two other bidders, Centene/FirstGuard and Coventry Health Care, Inc. filed protests of the awards with the Division of Purchases within the Kansas Department of Administration. The different elements of the protests were reviewed by the Director of Purchases, and the announcement that the original awards were officially upheld and reaffirmed was made on October 4, 2006.

A lawsuit for injunctive relief and appealing the contractual awards was also filed against KHPA by Centene/FirstGuard. On October 31, 2006 a decision was handed down by Shawnee County District Court Judge David Bruns to decline a permanent injunction and uphold the KHPA's award of managed care contracts. Shortly thereafter, on November 1, 2006, KHPA received news that UniCare Health Plan of Kansas, Inc., was issued its Certificate of Authority from the Kansas Insurance Department and Insurance Commissioner Sandy Praeger, allowing them to do business in the state.

The resolution of these immediate obstacles permits Kansas to move forward with the contracts that were awarded in the competitive bidding process. The customers are the priority, and our goal is for them to not experience any gap in service. We intend to continue our efforts toward a smooth transition for our providers and beneficiaries. UniCare, Children's Mercy Family Health Partners and KHPA share a common goal of providing quality health care services to Kansans, and we are pleased that we are now able to give Kansans a choice of plans.

KHPA continues to move forward in order to meet the implementation date of January 1, 2007. We are encouraging providers who wish to serve Medicaid and SCHIP beneficiaries to contract with the new MCOs, and we are committed to an orderly transition from the present contractor to its successors. While this may be the first transition of its type under the auspices of KHPA, we have an experienced team leading and managing the transition. In addition, we have asked individuals from several key stakeholders, including the Kansas Medical Society, the Kansas Hospital Association, the Kansas Medical Group Management Association, EDS (our Medicaid Management Information System contractor), and the Center for Medicare and Medicaid Services (CMS) to provide information to our transition team. In addition, we are working closely with the Kansas Department of Insurance and Commissioner Praeger to ensure as seamless a transition as possible, and have welcomed their assistance and guidance.

Recruitment of health care providers to contract with the new MCOs will be a priority over the next two months, and will be monitored closely by the KHPA. The MCO provider network is the key to delivering health care to beneficiaries and network development will be an on-going effort. In the past weeks, KHPA staff and representatives from UniCare and Children's Mercy FHP have been working to answer provider questions on a timely basis. We continue to hear positive news from vendors about provider enrollment and are confident in our transition plans for January 1, 2007.

KHPA also established a dedicated area on our website to provide a central easy access point to the most current and daily-updated information at www.khpa.ks.gov. Our goal is to provide all of our partners with information to provide for a smooth transition as we work together to deliver quality health care to Kansans. We look forward to working with you on our programmatic responsibilities for Medicaid, as well as future opportunities to shift the focus in health policy toward a broader view of improved health status for Kansans.

Eligibility Clearinghouse and the Challenges of the Federal Citizenship Requirement

New federal citizenship requirements went into effect on July 1, 2006. They require that all Medicaid applicants provide adequate documentation of citizenship and identification.

The requirement of additional documentation for each and every applicant has significantly altered the normal processes to apply for medical benefits. Each person applying for benefits is now required to submit either one primary document verifying citizenship and identity such as a passport or certificate of naturalization, or two secondary documents, one verifying citizenship, such as a birth certificate and one verifying identity, such as a drivers license or school id card. For example, in the past, an applicant with two children would submit an application on their own behalf and on behalf of their two children, and the necessary income verification documentation. Under the new rules, the same family would submit all of the same documents plus they need to submit an additional six documents -- two citizenship/identity documents per person.

Applicants are confused by what it is they are being asked to verify and what documents they need to provide. As a result, more cases are being pended because of missing documentation, and in turn, this generates more customer service phone calls. Since June, the number of customer service calls to the Kansas Family Medical Clearinghouse per month has doubled from 23,000 to 49,000, the number of voicemails has increased by ten times from 1,200 to 11,000, and the number of faxes has doubled to 6,000.

These additional documents are required to be submitted in hard copy form and have significantly strained many other processes and systems. The sheer volume of physical documents that are routinely received by the Clearinghouse has more than doubled since the implementation of this requirement. Each of these documents must be verified, processed and stored for future reference. As a result, the average amount of time it takes to complete the processing of a family's application has increased.

While the workload has increased significantly, the amount of staff has remained static. Prior to the implementation of these new requirements the Clearinghouse was working very hard to perform the necessary eligibility determinations, but since the implementation of the new requirements large amounts of unfinished eligibility work has been building up.

The first year of this requirement will be the most difficult, because each month this year the Clearinghouse will be conducting verifications for not only the 3,500 new applicants, but also for the 5,000 current beneficiaries who are scheduled for their annual eligibility review. After the verification has been performed for all current beneficiaries, the information will be kept on file for future access at the next review time and the requirements will only affect new applicants.

This new mandate impacts beneficiaries in many ways. First, we have denied coverage to 1,174 new applicants. At the time of their annual review, 1,552 beneficiaries lost coverage. We expect that many of these that have lost coverage will regain coverage once they have gathered and provided the necessary documentation. They will, however, experience a gap in coverage that could prove to be significant for some. Second, the decline in the number of beneficiaries from 271,258 in June to 252,871 in October may also show up in the caseload projection, making the projection too low and resulting in a shortfall in the estimation of funds necessary to run the program next year.

KHPA has taken measures to deal with some of these issues. We have reallocated some resources within our existing contract with MAXIMUS, who you will hear from this morning. However, reallocation has not been sufficient to remedy the situation. As a result, KHPA has made a supplemental request to add nine additional staff to the Clearinghouse for FY 2007. The Clearinghouse is vital to the agency's operations and meeting its mission. Without additional funding, we will place an unfair burden on Kansans who need these services the most. We must continue to provide access to health care for low-income Kansans, and funding these nine positions is a necessity as we move forward in the future.

We have also been actively working to obtain access to reliable interfaces that can provide some of the information required. The Kansas Department of Health and Environment has granted KHPA secured access to vital statistics information to take the place of obtaining hard copies of birth certificates. We are also in the process of discussing access to enrollment information with the Department of Education that can serve as one form of documentation for a child.

The KHPA Board is also concerned about declining enrollment and access to care for beneficiaries and will be providing more information to legislators and the public over the course of the legislative session.

Dental Program

Kansas has a total of 1,389 licensed active practicing dentists. As of September of 2006, there were 332 enrolled dental providers in the Title XXI program. This means about 24 percent of the State's dentists participate, and approximately 70% of these providers are actively billing for services.

For FY 2006, about 62% of the total 37,505 Title XXI beneficiaries received dental services. These services expenditures amounted to $6,753,572.

As of July 1, 2006 the contract with Doral for Title XXI dental services expired. The Division of Health Policy and Finance decided to change the Title XXI dental program from managed care to fee for service to be more similar to the Title XIX dental services. The goals were to reduce the complexity of the claims process for dentists, and to provide access to dental services to both the Title XXI and Title XIX beneficiaries through a seamless delivery model. Since this change, whether they are providing services for a Title XIX or Title XXI beneficiary, dental providers only have one entity to deal with for billing and claims payment
Dental providers can now use the EDS website to bill for services they have provided. Approximately one third of providers are utilizing this billing method, one third are billing electronically, and one third are billing on paper. Under the redesigned system, the claims are paid in an average of nine days.

Features of the EDS website included a five-year client history of dental services for providers to view, and dropdown menus for certain dental codes, allowing providers to record clinical information without needing to submit additional paperwork for payment processing.

The Kansas Dental Advisory Board meets quarterly, and is comprised of dentists, Kansas Dental Association Staff, KHPA staff, EDS staff, KDHE staff, and EDS' dental consultant.

Behavioral Health Contractor for Title XXI (SCHIP)

In May 2006, Cenpatico Behavioral Health (CBH) entered into a new contract with KHPA. CBH offers a comprehensive mental health benefit combining traditional mental health services with community based services of Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation group. CBH focuses on home-based family care and incorporates the whole family into the development of the treatment plan. This approach promotes independence by providing the tools and support necessary for the family to succeed.

CBH utilizes the Community Mental Health Centers as the core provider group and has included a number of "private sector" providers, such as Psychiatrists, Psychologists, and Licensed Clinical Social Workers (LSCSWs). This expanded network offers a greater choice of providers and treatment modalities for the HealthWave Title XXI members.

CBH provides case management and care coordination as a service to their members. Within these programs, members receive assistance locating providers and scheduling appointments, coordination of care with multiple providers, and assistance with locating community resources.

This change has not gone unnoticed, and there have been some challenges as members and providers have adjusted to a new approach in mental health service delivery. Concerns relate to the removal of some Community Based Services (CBS) previously provided to Medicaid members, increased authorization requirements for CBS services, and an increase in denied service requests. In addition, services were denied that did not meet CBH requirements for documentation, excessive units of service were billed, or services no longer covered were requested. These concerns have been evaluated and will continue to be monitored by KHPA. However, to date CBH has provided the services required by contract guidelines. Recent data suggests that both the provider community and beneficiaries are adjusting to CBH authorization requirements and the number of concerns have been reduced.

Future Directions – Presumptive Eligibility

KHPA is pursuing plans to implement a pilot program presumptive eligibility for the HealthWave program with a goal to expand statewide. Presumptive eligibility allows uninsured children who need immediate health care to access medical services and assures medical providers that the services will be reimbursed. Children will be determined presumptively eligible for services by qualified entities designated by the State. Qualified entities are trained to assess children utilizing a screening tool for presumptive eligibility and will notify the State if the child meets the requirements for a presumptive determination of eligibility. At that point medical benefits are available for 30 days while the designated entities assist uninsured children and their families with submission of a standard medical services application. This process ensures that families with uninsured children who are eligible will be properly enrolled in the appropriate health care program. After the eligibility determination is completed, children enrolled in Title XIX Medicaid or Title XXI are provided health care coverage for 12 continuous months. If a child's Medicaid application is not filed by the last day of the following month, the child's eligibility ends on that last day.

KHPA has estimated that approximately 40,700 children under the age of 19 are income-eligible for Title XIX Medicaid or Title XXI, but have not applied for either program. These children are the targeted population for presumptive eligibility. We will recruit hospitals and local health departments as qualified entities to conduct the eligibility screenings. Other states have recruited schools and used information collected for free or reduced

priced school lunches to identify children that meet the income requirements for presumptive eligibility.

In the summer of 2006, KHPA began two pilot sites to assist us in developing a statewide implementation plan for Presumptive Eligibility, which would occur after April 1, 2007. Children's Mercy Hospital in Kansas City and Via Christi Health System and Grace Medical Center in Wichita are participating in the pilot program. These sites have determined 506 children presumptively eligible for Title XIX and Title XXI.

As prescribed by the proviso contained in HB 2968, KHPA will report to the Legislature on the first day of the 2007 legislative session. KHPA will provide a plan for statewide implementation of the programat the state and provider level, the anticipated number of children served, and the cost and benefits of providing services under the program.

Future Directions – Community Health Record Pilot

One of the most exciting divisions of KHPA is our quality and innovation division that works to increase the quality of care that Kansans receive. KHPA is spearheading a pilot Community Health Record (CHR), which could revolutionize the way health care is delivered. This project began under the Division of Health Policy and Finance. Currently, this project reaches 14,000 individuals in the Medicaid and Health Wave managed care population of Sedgwick County. Launched in February 2006 in partnership with Cerner Corporation, the developer of the CHR application, and FirstGuard Health Plan, the Kansas Medicaid managed care provider, the purpose of the CHR is to improve the quality, safety and cost-effectiveness of care.

The CHR is a web-based, secure application built using clinical and claims health information, and is a component of a "Shared Electronic Health Record (EHR)" umbrella offering. The Shared EHR also offers additional services, including e-prescribing, Enterprise Master Person Index (EMPI), and lightweight documentation, including on-line, automated EPSDT forms. The CHR allows authorized providers online access to more than 12 months of aggregated claims data and health transactions regarding a person's office visits, hospitalizations, medications, immunizations, and lead screening data. Clinicians can document allergies and EPSDT screening information, and work is underway to incorporate lab results into the CHR. Essentially, it gives providers a one-stop point of access for information on their patients, improving the quality of care for Kansans. For example, it can reduce the redundancy of tests performed for a patient and allow the doctor to better evaluate and find solutions for the patient's illness.

As of August 2006, the CHR is being used by approximately 300 providers at 20 sites with the number of users gradually increasing week to week. There are currently 76 clinicians utilizing the e-prescribing component of the CHR. Feedback from users has been positive and emphasizes the simplicity and ease of use of the e-prescribing solution.

With the support of the Legislature, KHPA plans to utilize the information gained from the pilot to develop a request for proposal and conduct a competitive bidding process to obtain this type of shared health record for the statewide Medicaid population.

The project is scheduled to expire in December 31, 2006 with the end of FirstGuard's contract with the state. However, KHPA has requested funding to extend the pilot project through the end of FY 2007 in order to allow for more time to adequately evaluate the impact of the technology on patient care. The extension would be handled as a direct contract between Cerner and the KHPA, and it would allow providers in either of the two

managed care networks to participate.

Future Directions – Healthy Kansas First Five

As the leading agency on health and health care services, the Kansas Health Policy Authority is committed to providing access to care, especially care that is cost effective for the state in the long term. Approximately 15,000 Kansas children five-years old and younger are uninsured. To help give our children the critical healthy start in life, KHPA proposes expanding access to care for children through the creation of the Healthy Kansas First Five Program. This program would expand health care coverage to children age five and under from low and moderate income families who lack health care insurance by expanding low-cost insurance options through the HealthWave program.

This program was introduced last year by Governor Sebelius but not funded by the legislature. The KHPA Board considers access to care for Kansans a critical component of a coordinated health agenda for Kansas and this program in particular a high priority this upcoming legislative session.

Healthy Kansas First Five is designed to significantly reduce the number of uninsured children below the age of five. Nearly 11% of the Kansas population is uninsured, and most live in households with at least one worker. As the cost of health insurance continues to rise, an increasing number of working Kansas families cannot afford health insurance. Those working in small businesses are less apt to be offered insurance, and those with low and modest incomes often have difficulty affording health insurance. It is estimated that 2,000 children would be served in the first year of operation (2008), with additional enrollment expected thereafter.

To accomplish this, KHPA proposes to expand the upper income limit for the HealthWave program from the current level of 200% of the poverty level (yearly income of approximately $32,000 for a family of three) to 235% of the poverty level, and to create a state-only funded HealthWave option for young children in families up to 300% of the poverty level. Both components require families to pay a premium related to their level of income. Above 300% of poverty, families would be allowed to enroll their children at the full actuarial cost of the HealthWave benefit. To remain within Federal spending limits for the HealthWave program, this proposal may require some families with incomes between 133% and 200% of poverty be transferred from HealthWave Title XXI to HealthWave Title XIX coverage. Medicaid eligibility for pregnant women would also be increased to approximately 185% of poverty, increasing expectant mothers' access to prenatal care.

The KHPA Board voted in its November 2006 meeting to designate Healthy Kansas First Five as its top program priority for the 2007 legislative session. In addition, presenters at the various Board's Town Hall meetings offered support to this program. It is estimated to cost between $4 million and $6 million, annual cost SGF.

Summary

We appreciate the opportunity to come before the Children's Issues Committee and offer our testimony today. We look forward to working closely with you as we move toward a coordinated health agenda for Kansas. This concludes my testimony and I am happy to stand for questions. Thank you.

APPENDIX 1

HealthWave Income Eligibility